

# Greater Boston Gastroenterology

## PATIENT INFORMATION (Please Print)

Soc Sec # \_\_\_\_\_ Home Phone # \_\_\_\_\_

Last Name \_\_\_\_\_ Work Phone # \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Usual Provider (Please Circle): Fine, MD / Dickstein, MD / Oviedo, MD / Painter, MD / Taitelbaum, MD

Referring Doctor \_\_\_\_\_ Marital Status \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Employment Status \_\_\_\_\_

Current Medications \_\_\_\_\_

Allergies \_\_\_\_\_

## SUBSCRIBER INFORMATION

Last Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Work Phone # \_\_\_\_\_

Address \_\_\_\_\_ Sex \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Date of Birth \_\_\_\_\_

Zip \_\_\_\_\_ Soc Sec # \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Relationship:

Subscriber Name \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Certificate # \_\_\_\_\_ Patient Suffix \_\_\_\_\_

Group Name \_\_\_\_\_ Subscriber Suffix \_\_\_\_\_

Group # \_\_\_\_\_ Policy Phone # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Relationship:

Subscriber Name \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Certificate # \_\_\_\_\_ Patient Suffix \_\_\_\_\_

Group Name \_\_\_\_\_ Subscriber Suffix \_\_\_\_\_

Group # \_\_\_\_\_ Policy Phone # \_\_\_\_\_

\*\*\*\*PLEASE READ THE REVERSE SIDE\*\*\*\*

PATIENT # (for office use only) \_\_\_\_\_

## ADDITIONAL INFORMATION

Patient Cell # \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone # \_\_\_\_\_

**NOTE: All balances not paid by your insurance company due to lack of referral, deductibles, co-payments, or other limitations of your policy are the financial responsibility of the patient/guardian.**

## FINANCIAL POLICY

The following information describes our office procedure regarding various insurance carriers. If you do not have insurance coverage, payment is required at the time of service. If you have a special situation, please inform your physician.

## HEALTH MAINTENANCE ORGANIZATIONS

It is the patient's responsibility to obtain a referral from your primary care provider. All referrals should be received by our office at least one week in advance of your visit - unless an emergency. You will be responsible for any charges if a referral is not received. We regret having to be so strict about this, but the insurance carriers have made specific guidelines for the referral process. If we refer you to another specialist you must call your primary care provider to obtain a referral to that specialist.

Your co-payment is required at the time of service.

## MEDICARE

All charges are submitted to Medicare directly, and any deductible, co-payments or non-covered services are the patient's responsibility.

## MEDEX & MASS HEALTH

All charges are submitted to the insurance company directly.

## BLUE CROSS BLUE SHIELD of MA

Please be aware that BC/BS does not always pay for *screening* procedures. You may be responsible for payment of these procedures. If an endoscopic procedure is performed, the charges are submitted directly to BC/BS. You will then be billed for any non-covered service, co-payment or deductibles.

## Extended Authorization, Consent, and Authorization For Services Provided Without Referral

- I request that payments of medical benefits be made directly to the above named provider on any unpaid bills for services rendered to me on and after the below date.
- I further authorize the release of any medical information necessary to process this or related claims. I permit a copy of the authorization to be used in place of the original.
- I also understand that if I am an insurance member of an HMO, PPO, etc. that I have an obligation to obtain a referral for services prior to making an appointment. I acknowledge that if I do not have a referral or should any visit be denied for lack of referral, I will be responsible for payment of services received.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\*\*\*\*PLEASE READ THE REVERSE SIDE\*\*\*\*

PATIENT # (for office use only) \_\_\_\_\_

Date: \_\_\_\_\_

**REVIEW OF SYSTEMS**

**Constitutional/General**

- 10 lb wgt gain/loss in past year \_\_\_\_\_
- Fever within past month \_\_\_\_\_
- Chills or sweats \_\_\_\_\_
- Chronic fatigue \_\_\_\_\_

**Eyes**

- Blurred or double vision \_\_\_\_\_
- Cataracts or glaucoma \_\_\_\_\_

**Ears/Nose/Mouth/Throat**

- Hearing loss \_\_\_\_\_
- Ringing in the ears \_\_\_\_\_
- Sore throat/hoarseness \_\_\_\_\_
- Sinus problems \_\_\_\_\_
- Nose bleeds \_\_\_\_\_

**Cardiovascular**

- Chest pain/pressure \_\_\_\_\_
- Rapid or irregular heart beat \_\_\_\_\_
- Abnormal swelling in legs or feet \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Valvular disease \_\_\_\_\_
- Coronary Artery Disease \_\_\_\_\_

**Respiratory**

- Shortness of breath \_\_\_\_\_
- Wheezing or Asthma \_\_\_\_\_
- Persistent cough \_\_\_\_\_
- Coughing up sputum or blood \_\_\_\_\_

**NO YES  
COMMENTS**

- Exposed to Tuberculosis \_\_\_\_\_
- Difficulty breathing \_\_\_\_\_
- Difficult breathing on exertion \_\_\_\_\_
- Bronchitis \_\_\_\_\_

**Musculoskeletal**

- Pain/stiffness/swelling in joints \_\_\_\_\_
- Pain/stiffness in neck \_\_\_\_\_
- Backaches \_\_\_\_\_
- Muscle weakness \_\_\_\_\_
- Osteoporosis \_\_\_\_\_

**Gastrointestinal**

- Nausea or vomiting \_\_\_\_\_
- Vomiting of blood \_\_\_\_\_
- Heartburn \_\_\_\_\_
- Increase/decrease in appetite \_\_\_\_\_
- Gas or bloating \_\_\_\_\_
- Difficulty swallowing solids \_\_\_\_\_
- Difficulty swallowing liquids \_\_\_\_\_

**Abdominal pain**

Location \_\_\_\_\_  
 Related to \_\_\_\_\_  
 Relieved by \_\_\_\_\_  
 Frequency \_\_\_\_\_

- Constipation \_\_\_\_\_
- Diarrhea \_\_\_\_\_
- Blood in stool \_\_\_\_\_
- Mucous in stool \_\_\_\_\_
- Dark, tarry stools \_\_\_\_\_
- Jaundice \_\_\_\_\_
- Hepatitis \_\_\_\_\_

**Genitourinary**

- Frequency of urination \_\_\_\_\_
- Difficulty starting stream \_\_\_\_\_
- Leaking urine \_\_\_\_\_
- Burning/pain with urination \_\_\_\_\_

- Blood in urine \_\_\_\_\_
- Urinary tract infections \_\_\_\_\_
- Stones or kidney problems \_\_\_\_\_
- Frequent night urination \_\_\_\_\_

**Skin**

- Skin rashes \_\_\_\_\_
- Allergic reactions \_\_\_\_\_
- Breast tenderness \_\_\_\_\_
- Breast mass \_\_\_\_\_
- Prior breast biopsy \_\_\_\_\_

**Allergic/Immunologic**

- Allergies to drugs \_\_\_\_\_
- Food or other known allergies \_\_\_\_\_
- Ever had a blood transfusion \_\_\_\_\_

**Neurological**

- Frequent headaches \_\_\_\_\_
- Migraines \_\_\_\_\_
- Dizziness \_\_\_\_\_
- Problems with equilibrium \_\_\_\_\_
- Numbness or tingling \_\_\_\_\_
- Seizures or slurred speech \_\_\_\_\_
- Blacked out or lost consciousness \_\_\_\_\_

**Psychiatric**

- Anxiety \_\_\_\_\_
- Memory loss \_\_\_\_\_
- Depression \_\_\_\_\_
- Mental illness \_\_\_\_\_

**Endocrine**

- Excessive thirst/urination \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Thyroid disease \_\_\_\_\_

**Hematologic/Lymphatic**

- Enlarged glands (lymph nodes) \_\_\_\_\_
- Excessive bruising \_\_\_\_\_
- Abnormal bleeding \_\_\_\_\_

**Greater Boston Gastroenterology**  
**NOTICE OF PRIVACY PRACTICES**

*Effective Date: 4/14/2003*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION  
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU  
CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

**We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.**

Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law.

We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices*.

In the following pages, we explain our privacy practices and your rights to your health information in more detail.

**We May Use or Disclose Your Medical Information For:**

**Treatment:** We may use and disclose your medical information to provide you with medical treatment or services. For example, we may use your health information to write a prescription or to prescribe a course of treatment. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

**Payment:** We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider,

such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

**Health care operations:** We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use the information in your health record to assess the care and outcomes in your

case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. Greater Boston Gastroenterology sometimes contract with third-party business associates for services. Examples include answering services or transcriptionists. We may disclose your health information to our business associates so that they can perform the job we have asked them to do.

**Medical Residents and Medical Students:** Medical residents or medical students may observe or participate in your treatment or use your health information to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.

**Appointment Reminders:** We may use and disclose information in your medical record to contact you. For example as a reminder that you have an appointment, to report test results or for follow-up care. We prefer not to leave medical information about the patient. We may leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place.

**Treatment Options:** We may use and disclose your health information in order to inform you of alternative treatments.

**Release to Family/Friends:** Our health professionals, using their professional judgment, may disclose to a family member, or other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

**Disaster Relief:** We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition.

We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

**Public Health Activities:** We may disclose medical information about you for public health activities. These activities generally include the following:

- prevention or control of disease, injury, or disability;
- notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence.

We will make this disclosure when required by law, or if you agree to the disclosure, or when authorized by law and in our professional judgement disclosure is required to prevent serious harm.

**Funeral Directors:** We may disclose health information to funeral directors so that they may carry out their duties.

**Food and Drug administration (FDA):** We may disclose to the FDA and other regulatory agencies of the federal and state government health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing monitoring information to enable product recalls, repairs, or replacement.

**Research:** We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

**Worker's Compensation:** We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Law Enforcement:** We may release your health information when required for Law Enforcement.

**Personal Representative:** If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

**HLTV-III Test:** If we perform the HLTV-III test on you (to determine if you have been exposed to HIV), we will not disclose the results of the test to anyone but

you without your written consent unless otherwise required by law. We also will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

### **Authorization for Other Uses of Medical Information**

Uses of medical information not covered by our most current *Notice of Privacy Practices* or the laws that apply to us will be made only with your written authorization.

If you provide us with authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reason covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization or, if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provided to you.

### **Your Health Information Rights:**

You have the following rights regarding medical information we gather about you:

**Right to Obtain a Paper Copy of This Notice:** You have the right to a paper copy of this *Notice of Privacy Practices* at any time.

**Right to Inspect and Copy:** You have the right to inspect and request a copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records.

To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act (such as claims for Social Security, Supplemental Security Income, and MassHealth benefits) or any other state or federal needs-based benefit program.

\*\*We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed healthcare professional who was not directly involved in the denial of your request will conduct the review. We will comply with the outcome of the review.

**Right to Request Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information.

To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by Greater Boston Gastroenterology
- is not part of the information which you would be permitted to inspect and copy or
- is accurate and complete

If we deny your request for amendment, you may submit a statement of disagreement.

**Right to an Accounting of Disclosures:** You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or by fax).

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply.

**Right to Request Confidential Communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by phone at work or by mail.

To request a confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

### **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with The Office for Civil Rights in Boston, MA.

To file a complaint with us, contact our privacy officer at the address listed below. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

See the Office for Civil Rights website, [www.hhs.gov/ocr/hippa/](http://www.hhs.gov/ocr/hippa/) for more information.

Greater Boston Gastroenterology  
475 Franklin Street, Suite 110  
Framingham, MA 01702  
Attn: Privacy Officer

**Greater Boston Gastroenterology**  
**Acknowledgement of receipt of Notice of Privacy Practices**

ACCT#

NAME

PHYSICIAN

DOB

DATE

H#

LOCATION

W#

INSURANCE

ADDRESS

**I Acknowledge that I have received Greater Boston Gastroenterology's Notice of Privacy Practices.**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

If you are signing this acknowledgement in your capacity as a persons representative, please describe your authority to act on behalf of the patient and your relationship to the patient.

\_\_\_\_\_  
\_\_\_\_\_